MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Complete Medical Care 4126 Southwest Freeway, Ste. 700 Houston, TX 77027	MDR Tracking No.: M4-03-9440-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Clarendon National Insurance Co. Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 020584

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/06/03	**03/06/03**	**99245**	**$53.00**	**$53.00**

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a Position Summary.

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond to the request for MDR.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99245 for date of service 03/06/03. The requestor submitted a HCFA-1500 to the carrier identifying CPT Code 99245 as the service performed and $350.00 as the charged amount. Per the submitted EOB, the insurance carrier's audit company listed the reimbursed code as 99244 and allowed payment of $148.00 and used PEC "F – Fee guideline MAR reduction". The insurance carrier is in violation of Rule 133.301(b) and additional reimbursement of $53.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
3/6/2003	99245	$53.00	$53.00				
				Total Left Column:			$53.00
				Total Amount Due:			$53.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $53.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	01-28-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____